Mail To:
Wisconsin Medicaid
Prior Authorization
Suite 88
6406 Bridge Rd.
Madison, WI 53784-0088

PA/DGA

Prior Authorization
Drug/DMS Attachment
FOR LEGEND DRUGS

1. Complete the PA/DGA.
2. Attach to the Prior Authorization Request Form (PA/RF).
3. Mail to Wisconsin Medicaid.

Recipient Information

①	②	③	④	⑤
Last Name	First Name	M.I.	Identification Number	Age

Section A — Type of Request *Indicate start date requested/date prescription filled* (required) _____

❑ This prior authorization request for this drug, for this recipient, by this provider is ❑ New ❑ Renewal

Section B — Prescription Information (complete Section B *or* attach a copy of the prescription order)

Drug Name _____ Strength _____

Quantity Ordered _____ Date order issued _____

Directions for use _____

Daily Dose _____ Refills _____

Prescriber Name _____ DEA Number _____

"Brand Medically Necessary" is handwritten by the prescriber on the prescription order: ❑ Yes ❑ No

Section C — Clinical Information List the recipient's condition the prescribed drug is intended to treat. Include ICD-9-CM diagnosis codes and the expected length of need.

If requesting a renewal or continuation of a previous prior authorization approval, indicate any changes to the clinical condition, progress, or known results to date.

_____

_____

Attach another sheet if additional room is needed.

Source for Clinical Information (check one)

❑ This information was primarily obtained from the prescriber or prescription order.
❑ This information was primarily obtained from the recipient.
❑ This information was primarily obtained from some other source (specify): _____

_____

Use (check one)

❑ Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an ❑ accepted ❑ [bracketed] indication.
❑ The intended use above is *not* listed in compendial standards. Peer reviewed clinical literature is attached.

_____

_____

Dose (check one)

❑ The daily dose and duration are within compendial standards general prescribing or dosing limits for the indicated use.
❑ The daily dose and duration are *not* within compendial standards general prescribing or dosing limits for the intended use. Attach peer reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference.

Signature _____ Date _____

Check the appropriate box:
Please notify me of approval/denial by ❑ Fax # _____ ❑ Telephone # _____ ❑ No notice needed

The pharmacist/dispenser must review information and sign and date this form!